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	175385	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK	200 SW 14TH NEWTON, KS 67114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility reported a census of 101 residents, with 18 sampled for review. Based on observation, interview, and record review, the facility failed to ensure communication between the facility and the dialysis center, to assure the necessary cares to maintain the highest practicable physical, mental, and psychosocial well-being, for one (#82) of 1 resident reviewed with dialysis services. Findings included: - The resident's electronic medical record revealed a diagnosis of end stage renal disease (a terminal disease because of irreversible damage to vital organs, the kidneys). A quarterly MDS (Minimum Data Set), dated 7/8/14, revealed the resident with severe cognitive impairment, with a BIMS (Brief Interview for Mental Status) score of 4, and signs of delirium included disorganized thinking which fluctuates. Behavioral symptoms included rejection of care, which occurred 1 to 3 days	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 309	Continued From page 1 during the 7 day look-back period, and identified the resident required dialysis while a resident of the facility. The care plan, last reviewed 7/22/14, identified a section for dialysis, and included interventions of how to care for the resident before and after the resident goes to the dialysis center, monitoring blood pressure, weight, and the dialysis site for bleeding. The care plan lacked any interventions of communicating the resident concerns with the dialysis center. The nurse's note, for 7/18/14 at 8:46 PM, revealed the resident returned from dialysis and received a late lunch. The nurse's note, for 7/21/14 at 8:35 AM, revealed the resident became verbally aggressive about going to dialysis. Staff redirected the resident by taking him/her outside. The nurse's note failed to document any notification to the dialysis center about this resident's behavior related to the dialysis services. On 7/22/14 at 7:41 PM, direct care staff BB encouraged the resident to eat his/her breakfast related to needing to go to dialysis today. Then, direct care staff CC obtained the resident's vital signs. At 8:44 AM, the direct care staff DD propelled the resident out of the house/ facility. Staff DD notified staff CC of leaving the facility with the resident. The resident lacked any paperwork for the dialysis center. On 7/23/14 at 2:15 PM, the resident sat at the table and consumed 100% of the meal. At 2:22 PM, the resident ambulated to his/her room without assistance.	F 309		

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F 309	Continued From page 2 On 7/23/14 at 2:30 PM, licensed nursing staff EE reported the resident returned to the facility from the dialysis center at 2:05 PM. Staff EE reported the resident weight is usually 3-4 pounds less upon returning to the facility. Staff EE also reported monitoring the dialysis site, blood pressure, and increased monitoring related to falls upon his/ her return to the facility. Staff EE confirmed no paper work went with the resident to the dialysis center. Staff EE added, the only time the facility staff knows of problems, is if the dialysis center calls and has a complaint related to the resident's behaviors. Approximately every 3 months, the dialysis center will send lab (laboratory) results, a summary of labs, and a note from the registered dietician. Furthermore, staff EE reported the dialysis center has not called for a while, since the facility started administering an anti-anxiety medication prior to sending the resident to the dialysis center. On 7/24/14 at 3:22 PM, licensed nursing staff FF stated the facility has never sent papers to, or receives papers back from the dialysis center. Staff FF added, ever so often the dialysis center will send something, but not very often. The dialysis center does call us if the resident is having a behavior problem. Unless the dialysis center calls the facility, staff FF assumes the resident did fine. On 7/24/14 at 4:00 PM, administrative nursing staff G confirmed the resident goes to dialysis three times a week, and communication with the dialysis center is completed through phone call calls. Staff G added the facility is treating the dialysis center visits like a doctor's appointment and paper work goes with the resident. Staff G reported the expectation of phone calls each time the resident goes and comes back, especially if	F 309		

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F 309	Continued From page 3 the facility is not sending paperwork. The facility's undated Dialysis AV (Arteriovenous) Fistulas/ AV Grafts, failed to include the communication practices between the facility and the dialysis center. The facility failed to ensure communication between the facility and the dialysis center, to assure the necessary cares to maintain the highest practicable physical, mental, and psychosocial well-being, for one (#82) of 1 resident reviewed with dialysis services.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This Requirement is not met as evidenced by: The facility reported a census of 101 residents. The 18 residents sampled included 3 residents reviewed for rehabilitation. Based on observation, interview, and record review, the facility failed to provide a restorative program to maintain the ability to walk for 1 resident (# 36), of the 3 reviewed residents. Findings included: - Resident #36 admitted to the facility on 5/9/14, per the 5/16/14 MDS (minimum data set) assessment. The assessment documented the resident with a BIMS (brief interview for mental status) score of 14 which indicated the resident with intact cognition. The assessment also documented the resident required supervision with eating,limited staff assistance with personal	F 311		

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hygiene, and extensive assist with the remaining ADLs (activities of daily living), and with an active discharge plan.

The 5/16/14, cognitive CAA (care area assessment), documented the resident with a a history of mild mental retardation,(a general learning or developmental disability), bipolar disorder, (a major mental illness that causes people to have episodes of severe high and low moods), and encephalopathy (an inflammatory condition of the brain) secondary to cellulitis, and is not the best historian, He/she is very stoic (does not typically complain of pain when present). The resident was hospitalized twice in the past 35 days, with infections.

The 5/16/14 ADL CAA, documented the resident came to the facility from a hospital rehabilitation unit after an emergency exploratory surgery for the repair of a perforated (punctured) bowel and large incisional hernia. Prior to that, the resident was in the critical care unit, and with severe septic with acute end stage organ damage, secondary to bowel perforation and acute respiratory insufficiency. A wound vac was paced at the surgical incision site, and the resident is seen at a wound clinic routinely.

The 5/27/14 care plan, documented the resident able to make needs known when he/she desires. The resident needs assistance with ADLs, and has knee pain at times. He/she uses the call light to request assistance out of the chair. The resident uses a front wheeled walker for ambulation with one staff to assist and a wheelchair used for long distances.

Review of the resident's electronic record revealed the resident's discharge plan is

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uncertain at this time. The resident would like to return to assisted living once all acute care needs are resolved.

On 7/22/14 at 4:56 PM, the resident reported he/she did get special therapy services, but it had stopped. The resident added further he/she was in the hospital, had surgery and when he/she came back, was moved from the assisted living area to the nursing home side. The resident reported the facility said he/she needed more care. He/she added the hope to move back to the assisted living area soon. The resident explained that at first when he/she came back from the hospital, the resident had to use a wheelchair, but now used the walker. He/she reported the facility wanted him/her to walk with someone, in case he/she had a fall, and further explained the staff used a belt around the resident also.

On 7/22/14 at 5:08 PM, direct care staff V, assisted the resident to stand from the recliner, with a gait belt on and walked with the resident to the bathroom. The resident pulled down their own pants and sat on the stool. When the resident finished, he/she stood, and staff instructed the resident to hold onto the bar, as staff completed personal hygiene cares. Staff V removed their gloves and assisted the resident to adjust their clothing. The resident held the walker as staff washed his/her hands. Then the resident and the staff member walked to the dining room.

On 7/22/14 at 5:22 PM, direct care staff V, reported the resident used a wheelchair at first, worked with therapy, and now used a walker to ambulate, with the staff walking beside. Staff V added the resident liked to walk in the halls and wanted to go back to the assisted living area.

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F 311	Continued From page 6 On 7/23/14 at 10:12 AM, direct care staff W reported being the restorative aide, and that the resident received special therapy, and did not know if the special therapy ended yet. Staff W reported the resident not currently receiving restorative services. Staff W explained further, usually a resident finished therapy, then therapy wrote a restorative program for the resident and the restorative staff to follow. However, this resident lacked a restorative program plan. On 7/23/13 at 2:10 PM, consultant staff Y reported the resident was no longer on therapy services. Staff Y reported the resident wanted to go back to assisted living, but the family wanted the resident to stay a while longer at the facility. The resident's family member did not want the resident doing a lot of walking. Staff Y reported the usual procedure is to provide a written restorative program to the restorative staff when the resident completed therapy. However, Staff Y was unable to find a written restorative program for the resident. Staff Y added he/she felt the resident would benefit from a restorative program. On 7/23/14 at 3:09 PM, consultant staff Z, reported the resident received physical and occupational therapy and finished these therapy services on June 26, 2014. Staff Z, added the resident met all goals and his/her family thought it was best the resident remained in the nursing facility for a while longer. Staff Z added the resident should have a restorative program to continue with after the therapy ended. Staff Z explained, they would usually write a restorative program when the resident's discontinue from the therapy services. Further explanation included, after the therapy is discontinued and a restorative	F 311		

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F 311	Continued From page 7 program is written, the therapists give the program to the Social Services Department. The resident should have a restorative program, but it never got set-up. On 7/23/14 at 3:19 PM, licensed nursing staff AA, reported the resident did have therapy and the usual facility procedure would be to do a restorative program when therapy was completed. On 7/23/14 at 3:30 PM, administrative nursing staff C reported, he/she had no idea why the resident did not have a restorative program. Staff C, added the resident had finished with therapy, and needed a restorative program now. Staff C, added further the restorative program was next on his/her list, to address. Staff C, reported employment started in April ,2014 and staff C had a list of things they are working on. Staff C reported there is not a specific facility nurse assigned to oversee the restorative program, so I am the one responsible. This resident would benefit from a restorative program to maintain what he/she has gained with the special therapy services. The facility failed to establish a restorative program for this resident upon discharge from special therapy services, to ensure the resident maintained their highest practicable physical ability of walking and ADLs.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		

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catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This Requirement is not met as evidenced by:
The facility reported a census of 101 residents, with 18 selected for sample review. Based on observation, interview, and record review, the facility failed to ensure 1 resident (# 41) of 2 sampled reviewed for catheter (tube placed in the bladder to drain urine into a collection bag) use, received necessary services to prevent urinary tract infections and to prevent urethral trauma related to the use of the indwelling urinary catheter. (tube placed in the bladder to drain urine into a collection bag).

Findings included:

- The facility admitted resident # 41 on 5/9/14, per the clinical record, patient information document, dated 5/9/14.

A diagnosis from the ECR (electronic care record), included urinary retention (lack of ability to urinate and empty the bladder).

The resident's 5/16/14 significant change MDS (minimum data set) assessment, identified intact cognition for the resident. The resident needed extensive assistance of 2 staff for transfers and toileting, identified the use of an indwelling urinary catheter, and urinary tract infections (in the last 30 days).

The 5/16/14 CAA (care area assessment) for urinary incontinence and urinary catheter,

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identified the resident with a history of urinary indwelling catheter due to urinary retention, with staff managing the catheter.

The resident's 4/22/14 care plan instructed staff the resident needed:

1. Foley catheter due to urinary retention, with continuous indwelling Foley to be changed every 3 months per policy and irrigate PRN (as needed).

2. Female staff to assist with pad changes and perineal care.

3. Monitor for signs and symptoms of UTI (urinary tract infection).

4. Maintain a closed drainage system using aseptic technique when emptying the drainage bag.

5. Foley catheter and pericare done with every shift and PRN. Empty the Foley (tube placed in the bladder to drain urine into a collection bag) drainage system every shift and record the amount of output.

A 5/28/14 Incontinence/Constipation Assessment, identified the resident's use of an indwelling Foley catheter. Additionally, the assessment identified the hospital inserted and placed the resident's indwelling urinary catheter on 5/8/14, and instructed staff to perform good pericare with each brief change and to provide catheter care each shift and with each bowel movement.

The only observation of catheter care allowed by the resident, on 7/22/14 at 4:47 PM, included, direct care staff Q and M checked and changed

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the resident following an incontinent bowel movement. Staff failed to clean from the insertion point of the catheter in a downward motion to remove any debris. The staff completed perineal care, however, failed to provide complete catheter care cleansing, with the resident having visible feces in the urethral area. Additionally, observation at that time identified the catheter unsecured and it moved freely pulling during the care provided.

On 7/23/14 at 12:00 PM, direct care staff O, reported the resident needed 2 persons for transfers and used an indwelling catheter for urinary continence. The staff reported the resident needed catheter care every shift, including wiping front to back and cleansing of the catheter tubing with perineal wipes from the insertion site downwards the length of the catheter.

On 7/24/14 at 2:30 PM, direct care staff T, reported the residents that used indwelling catheters required anchoring of the tubing, to secure it and to prevent pulling and tugging at the insertion site (urethra). The staff typically used a butterfly anchor (type of tape anchor). However, the butterfly tape did not always stick very well to this resident's skin.

On 7/24/14 at 2:30 PM, licensed nursing staff K, reported that direct care staff are expected to complete catheter care every shift for this resident, and that due to incontinence of bowel movements, the resident also required catheter care following each incontinent bowel movement, cleaning from the insertion site downwards the length of the catheter, using perineal wipes. Additionally, the staff reported all residents using an indwelling catheter needed an anchor to the

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F 315	Continued From page 11 resident's thigh area. The staff reported they lacked awareness the resident currently lacked an anchor. On 7/24/14 at 4:30 PM, direct care staff Q reported the staff should have completed perineal care using a perineal wipe, cleansing from the insertion site downwards, the length of the tube, following the bowel incontinence. On 7/24/14 at 5:00 PM, administrative nursing staff C, reported the staff are trained regarding catheter care and always cleaning the catheter following incontinence of bowel movement. Furthermore, the residents with catheters should always have an anchor to secure the tubing to the resident's body. The facility undated policy, for Catheter Positioning and Care of Indwelling Urinary Catheter, instructed staff to secure the catheter tubing to the abdomen or inner thigh of the resident, and to perform perineal care as needed, or daily. The facility failed to provide necessary care and services to prevent urinary tract infections and to prevent ureathral trauma, for this resident, with an indwelling urinary catheter.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		

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F 325	Continued From page 12 nutritional problem. This Requirement is not met as evidenced by: The facility reported a census of 101 residents. The 18 residents selected for sample included 4 reviewed for nutritional status. Based on observation, interview, and record review, the facility failed to ensure 1 (#103) of the 4 residents reviewed for nutritional status, received nutritional interventions to maintain acceptable parameters of body weight. Findings included: - Resident # 103 admitted to the facility on 9/24/13, per the 9/30/2013 MDS (minimum data set) assessment. The assessment further documented the resident with a BIMS (brief interview for mental status) score of 5, (score of 0-7 indicates cognition severally impaired) and required staff supervision with eating, with a lack of any nutritional approaches, and a current weight of 95 pounds. The 9/30/13, nutritional status CAA (care area assessment), documented the resident on a regular diet and able to feed him/herself with set-up assistance and supervision. Documentation revealed the resident's appetite very poor on arrival but has slowly picked up. The resident now eats 75 % on average, and with a current weight of 95 pounds. The 6/24/14 quarterly MDS, identified the resident with a weight loss and a current weight of 89 pounds. The assessment revealed no physician order for a weight loss diet/program.	F 325		

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F 325	Continued From page 13 The 7/1/14 care plan, documented as follows for nutrition: Monitor meal intake and document in care tracker. Assess response to diet and request order for modification as needed. Allow the resident to make as many choices as possible within limits of his/her diet. Regular diet with ground meat. If food intake is less than 25% offer a health shake. House supplement TID (three times daily). Monitor meal intake and document in care tracker. Assess response to diet and request order for modification as needed. Allow the resident to make as many choices as possible within limits of his/her diet. Review of documentation in the resident's meal monitor, from 5/24/14 to 7/22/2014, revealed the resident refused the meal or consumed less than 50% of the meal, on 8 occasions for breakfast, on 11 occasions for lunch, and on 19 occasions for dinner. The documentation further revealed the resident did not accept or refused the morning snack on 37 occasions, the afternoon snack on 27 occasions, and the evening snack on 53 occasions. The medical record documented the resident's weights, in pounds, as follows: On 1/5/14=98 pounds. On 2/2/14=98.2 pounds. On 3/2/14= 86 pounds. On 3/29/14=92 pounds. On 4/07/14=95.2 pounds.	F 325		

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F 325	Continued From page 14 On 5/4/14=92.2 pounds. On 5/25/14=89.2 pounds. On 6/6/14=89 pounds. On 6/8/14=90.2 pounds. On 6/11/14=75.8 pounds, with a re-weigh on 6/14/14. On 6/14/14= 80 pounds. On 6/24/14= 89 pounds. On 6/28/14= 89.9 pounds. On 7/5/14= 92 pounds. On 7/13/14=90 pounds. On 7/21/14= 94 pounds. Observation on 7/22/14 at 5:16 PM, revealed the resident served french toast (1 slice) and a serving of ground sausage. Staff cut up the french toast after applying butter and syrup. The resident ate and drank independently, but took only a few bites. However, no staff assisted or encouraged the resident to eat more, or offered the resident the healthshake with less than 25 % of the meal taken. Observation on 7/22/2/14 at 5:40 PM, revealed direct care staff Q sat at the table with the resident and offered the resident bites of food. However, the resident indicated he/she was done. The staff talked with the resident for a few minutes without any further offers or encouragement to eat, or the healthshake with less than 25% of the meal taken. The resident appeared to push away from the table, and began to remove the clothing protector. At 5:55 PM, a dietary staff offered the resident a lemon bar and ice cream for dessert. The resident failed to eat the lemon bar, but did consume the ice cream without encouragement or cueing. On 7/23/14 at 11:05 AM, direct care staff N reported if the resident refused to do a task, staff	F 325		

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F 325	Continued From page 15 would calmly explain the reason for the action, then the resident usually would cooperate. Staff N added the resident was very confused and needed extra attention at times. On 7/23/14 at 8:30 AM, direct care staff GG reported the resident received a 4 ounce glass of 2-cal med pass at breakfast, and usually took it without difficulty. On 7/23/14 at 3:00 PM, consultant staff E reported the facility did recognize the resident had lost weight, and implemented a supplement. He/she reported the resident gaining weight was proof that the intervention was working, and staff were not concerned related to the lack of documentation of the resident's intake. On 7/24/14 at 11:30 PM, licensed nursing staff J, reported the facility had no weekly weight meeting, but reported the dietary manager does review weights and this resident is on the significant weight change report. Staff J provided information from the last meeting on 7/21/14, which documented the resident's . weight as 94 pounds, which resulted as a 5.3% increase in weight. The report further documented the TID supplement started on 6/9/14. The facility failed to ensure this dependent resident received nutritional supplements of healthshakes when less than 25% of the meal was consumed by the resident.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This Requirement is not met as evidenced by:
The facility reported a census of 101 residents. The 18 residents selected for samples included 5 reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to adequately monitor 2 residents (#75 and #103) reviewed for unnecessary medications, for adequate bowel movements related to the medications.

Findings included:

- The facility admitted resident #75 on 5/20/11, per the ECR (electronic care record), with diagnosis including constipation (difficulty passing stools).

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F 329	Continued From page 17 The resident's 3/4/14 annual MDS (minimum data set) assessment, identified the resident scored 13/15 on the BIMS (brief interview for mental status), indicating intact cognition, and required supervision for ADLs (activities of daily living), including toileting. The resident's 3/18/14 care plan, instructed staff the resident was independent with ADLs and lacked any further instruction related to the use of laxatives or BM (bowel movement) monitoring. Review of the resident's POS (physician order summary), dated 7/9/14, included the following order: 1.) Senokot S, 1 tablet daily, for constipation, ordered 4/2/14. The BM report, dated 6/24/14 to 7/24/14, identified the resident lacked a BM; From 6/30/14 to 7/2/14, (a 3 day period). From 7/4/14 to 7/6/14, (a 3 day period). From 7/8/14 to 7/12/14, (a 5 day period). From 7/14/14 to 7/18/14, (a 5 day period). From 7/20/14 to 7/22/1, (a 3 day period). From 7/20/14 to 7/22/14, (a 3 day period). Observations, on 7/22/14 at 4:18 PM, on 7/23/14 at 8:00 AM and 9:30 AM, identified the resident independently ambulatory with the use of a roller walker, and other activities of daily living, including eating and transferring. On 7/23/14 at 11:05 AM, direct care staff N reported the resident did not need much help, just reminders and cueing. On 7/24/14 at 2:15 PM, licensed nursing staff K, reported the resident as a very independent	F 329		

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person, performing most ADLs independently, but staff continued to need to monitor bowel movements.

On 7/24/14 at 5:00 PM, administrative nursing staff B reported a resident should never be allowed to go 4 to 7 days without a BM.

Licensed nursing staff L, reported on 7/24/14 at 6:43 PM, the resident should never go 4 to 7 days without a BM. The staff further reported they did not recall the resident used PRN's (as needed medications) for constipation, very frequently. Staff L reported the nurses review the "NO BM" report daily, then instruct the CMAs (certified medication aides) to administer PRN's, as needed.

On 7/24/14 at 6:45 PM, direct care staff T reported the staff are expected to ask the resident daily about bowel movements, and record the information in the care tracker program.

The undated, facility policy for Bowel Function Tracking, instructed the staff responsible for care of each elder to document BM's on the BM form each shift. The licensed nurse and CMA (certified medication aide) will review the BM sheet each shift. CMAs observing a resident without a BM for 2 days are required to report this to the charge nurse with administration of a PRN (as needed) laxative given per the standing orders.

The facility failed to adequately monitor the resident's BMs to ensure routine BM functioning and medications as needed for this resident who went several times for 3 to 5 days without a BM or PRN medication to prevent constipation.

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F 329	Continued From page 19 - The MDS (minimum data set), dated 09/30/2013, documented resident #103 admitted to the facility on 09/24/2013. The assessment further documented the resident with a BIMS (brief interview for mental status) score of 5, indicating severely impaired cognition. The resident was always continent of bowel without constipation. The electronic record documented the resident had an irritable bowel syndrome (abnormally increased motility of the small and large intestines). The ADL (activities of daily living) CAA (care area assessment), dated 09/30/2013, documented the resident depended on 1 staff for toileting. He/she uses FWW (front wheeled walker), but no longer ambulates as much as he/she did upon admission. The care plan, dated 07/01/2014, documented the resident needed assistance with some ADLs, 1 assist with transfers, and with a history of falls. Routine toileting, wears pull-ups for mixed incontinence, is dependent for his/her toileting due to cognition/dementia and is at risk for constipation due to history of constipation. The physician order sheet, dated 06/20/2014, documented orders for; 1.) Hydrocodone (pain medication) 5/325 mg (milligrams) every six hours for pain PRN (as needed), ordered on 3/31/14. 2.) MOM (milk of magnesia-laxative) 30 ML (milliliters) every 12 hours, PRN for constipation, ordered on 3/31/14. 3.) Colace (Stool softner)100 mg, daily for constipation, ordered on 4/3/14.	F 329		

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4.) Tramadol (pain medication) 50 mg daily for pain, ordered on 4/9/14.

The electronic medical record for monitoring the resident's BMs, revealed the lack of a BM from 06/16/2014 to 06/25/2014, for a total of 8 days without a bowel movement.

The nurse's note, dated 06/25/2014 at 1:55 PM, documented the resident complained of not being able to have a BM, the nurse completed a rectal check with the resident expelling an extra large amount of hard bowel movement.

On 07/23/2014 at 12:33 PM, direct care staff N reported, the CNAs charted on the computer when the resident had a bowel movement and they also report to the nurse if the resident has not had a bowel movement for 2 to 3 days.

On 07/24/2014 at 2:20 PM, license nursing staff X advised, if a resident goes 3 days without a bowel movement, they give MOM, on the 4th day they give a suppository, and the next day call the doctor.

On 07/24/2014 at 2:30 PM, license nursing staff J reported, the usual procedure is to give MOM after 3 days without a BM (bowel movement), then give a suppository on the 4th day and then call the doctor.

On 07/24/2014 at 3:20 PM, administrative nursing staff C, advised he/she expected the charge nurse to get an order for MOM if the resident did not have one and/or a suppository when the resident went 3 days without a BM. Staff C reported after that the physician should be notified of the situation.

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F 329	Continued From page 21 The facility failed to monitor this resident's BMs to ensure the resident received no unnecessary medications.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 117 resident, with 53 residents served meals from the main kitchen and a satellite kitchen. Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary dietary department, for the food storage, preparation, and service for the 53 residents served in the main facility. Findings included: - Sanitation tour of the main kitchen on 7/23/14 at 10:20 AM, revealed the following areas/items of concern: 1.) Four bowels held visible water droplets, stored on the shelves, ready for use. 2.) Six large steam table pans, held visible water on the inside and outside of the pans, stored on the shelves, and ready for use.	F 371		

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F 371	Continued From page 22 3.) One small steam table pan, contained a darkened build-up area around the inside bottom of the pan. 4.) One large steam table pan, stored and ready for use, held visible dried food along all of the insides and on the bottom of the pan. On 7/24/14 at 10:45 AM, dietary staff D, verified the above pans needed cleaned, and dried before storage. On 7/23/14 at 12:14 PM, sanitation tour in the satellite kitchen revealed the following areas/items of concern. 1.) Down the side of the grill, contained a build-up of grease and food crumbs. 2.) Seven large cookie sheets held a build-up of dark debris along the insides of the pans. On 7/23/14 at 12:25 PM, dietary staff JJ, verified these cookie sheets needed cleaned. On 7/23/14 at 12:30 PM, dietary staff II, reported the grill is cleaned weekly, and the surrounding area wiped down. The staff verified the side of the grill, needed scraped to get all of the food and grease to come off of it. The facility failed to maintain a clean and sanitary department for the storage, preparation, and service of food to the 53 residents served from the main kitchen and the satellite kitchen.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 23 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility reported a census of 101 residents. Based on observations, interviews, and record	F 441		

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review, the facility failed to adequately clean the glucometers between resident usage, to minimize risk of infections and cross contamination for the 33 residents of the facility that required glucometer checks. Furthermore, the facility failed to handle soiled linens appropriately to prevent the potential spread of infections to the residents of the facility.

Findings included:

- On 7/23/14 at 4:15 PM, direct care staff HH obtained the glucometer and plastic tray with supplies from a locked cabinet, and entered resident #83's room. Staff HH placed the plastic tray directly onto the night stand, without a protective barrier. Staff HH, then placed the glucometer machine directly on the edge of the chair, obtained the blood sample and notified the resident of the result. Staff HH, then returned the glucometer into the plastic tray and returned it to the locked cabinet in the nurse's desk/office. Staff HH failed to clean the glucometer or tray before or after obtaining the blood sample.

On 7/23/14 at 4:44 PM, licensed nursing staff EE retrieved the glucometer and supply tray, entered resident #82's room, and set the tray directly onto the resident's bed, without a protective barrier. Staff EE obtained the blood sample with results, returned the glucometer into the supply tray, and then returned the tray to the cabinet in the nurse's office. Staff EE failed to clean the glucometer or tray before or after obtaining the blood sample. When questioned, staff EE reported and verified not doing anything with the glucometer before returning it to the holding basket/ tray, or into the cabinet. At 4:59 PM, licensed nursing staff EE reported the glucometer should be cleaned between residents use, but was not sure of what

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F 441	Continued From page 25 to clean it with, and confirmed he/she failed to clean the glucometer before returning it to the cabinet. On 7/24/14 at 4:45 PM, licensed nursing staff L obtained a blood sample with results, and cleaned the glucometer with an alcohol wipe and returned the supplies to the treatment cart. Staff L reported this was the normal procedure and the policy directed for the cleaning of the glucometer with alcohol between each resident use. On 7/24/14 at 5:21 PM, administrative nursing staff G, reported staff should follow the policy, and they should clean the glucometer with something that kills (bacteria). Staff G listed, from the policy, the use of Iso-propyl alcohol or bleach solution. Staff G added, the tray should be cleaned before staff set it on the bedside table. The facility provided ASCP's (American Society of Clinical Pathologists') Summary of Glucometer Cleaning Guidelines, February 2010, included If glucometers are shared, the device must be cleaned and disinfected between each patient use. Because of possible inadvertent contamination, unused supplies and medications taken to a patient's bedside during fingerstick monitoring or insulin administration should not be used for another patient. The glucometer manufacturers's recommendations included Meter care, wipe meter with clean lint-free cloth dampened with one of the following: Mild detergent or mild soap and water, 10% household bleach and water. The facility failed to adequately clean the	F 441		

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glucometers between resident usages, to minimize risk of infections and cross contamination for the residents of the facility that require glucometer checks.

- Observation on 7/23/14 at 10:40 AM, identified direct care staff N assisted resident # 12 with toileting, perineal care, and changing the resident's urine wet clothing. Following completion of the personal hygiene and clothing change, the staff member removed the urine wet personal clothing from the resident's room, unbagged, and then ambulated in the hall way to the soiled linen room. During the observation of staff member N ambulating to the soiled linen room, another housekeeping staff member R, approached the soiled linen room, with an armful of unbagged soiled linens. Staff R disposed of the linens in the closed room, then washed his/her hands.

Interview at that time, with housekeeping staff R, reported the soiled items, if not wet or soiled with feces, may be transported through the hall ways, without bagging, however, if wet or soiled with body fluids, the items must be bagged.

Interview on 7/24/14 at 5:00 PM, with administrative nursing staff C reported the staff needed additional education on linen handling, based on the above findings.

The facility failed to maintain adequate infection control practices, when the staff transported unbagged soiled linens from a resident room into a common living area of the facility.